Barnett Vision Clinic

Patient Information:

Date:___/____/____

Last Name:_____First Name:_____MI:_____DOB___/___/___

M or F SSN:_____/_____/_____ Marital Status: Married/Single/Divorced/Widowed

Address:_____City_____State_____Zip_____

Home Phone:_____ Cell Phone_____Work Phone_____

Employer/School_____Occupation/School Grade_____

Emergency Contact:_____Relationship_____Phone #:_____

Responsible Party: (if same as above please leave blank)

Last Name:_____First Name:_____MI:_____DOB___/___/___

M or F SSN:_____/_____/_____ Marital Status: Married/Single/Divorced/Widowed

Address:_____City_____State_____Zip_____

Home Phone:_____ Cell Phone_____Work Phone_____

Employer/School_____Occupation/School Grade_____

Insurance Information:

Primary name on insurance: Last name:_____First Name:_____

Insurance Carrier: Primary:_____ Secondary:_____

Member ID #_____Group #:_____

(Please provide copies of insurance cards or provide primary social for Tricare and VSP insurance)

Medical History:

Date of Last Medical Exam: ____/____/_____Primary Care Physician/Clinic:_____

Date of Last Eye Exam: ____/_____/_____ Eye Doctor/Clinic:_____

Do you wear glasses? Never/All of the time/Sometimes/Work Only/Reading Only/Driving Only

How old are your present glasses:_____ Do you wear prescription sun wear? Yes/no

Do you wear contacts? Yes/No Brand:_____Solution Used:_____

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Wearing Schedule: Daily/Overnight Replacement Schedule: Daily/2 weeks/monthly/yearly

Have you ever had an eye injury? Yes/No (if yes which eye)_____

Have you ever had eye surgeries? Yes/No (if yes please explain)_____

Have you used eye medication? Yes/No (if yes, which meds)_____

Are you pregnant or nursing? Yes/No/NA

Have you ever been diagnosed with:

Cataracts: Yes/No When were you diagnosed?_____

Glaucoma: Yes/No When were you diagnosed?_____

Macular Degeneration: Yes/No when were you diagnosed?_____

Please List any medications you are taking and dose (or provide a list)_____

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